UTAH ACCIDENT & HEALTH SURVEY INSTRUCTIONS

All Fraternal, Health, Life and Property & Casualty insurers in Utah who report accident and health business on the Utah State page of the NAIC Annual Statement are required to complete and file this annual survey. All other insurers are exempt. The completed survey form should be mailed to the Utah Insurance Department **by March 1, 2008**. Submissions may also be made via email to jhawley@utah.gov. Failure to file by the deadline may subject your company to the enforcement penalties under Utah Code Annotated § 31A-2-308. Any questions on completing this survey form should be directed to Jeff Hawley, Research Analyst at (801) 538-9684.

This survey is designed to collect accident and health data in greater detail than is reported on the Utah State page of the NAIC Annual Statement. The survey follows definitions and categories used in the NAIC Annual Statement as much as possible. All data values reported on the survey form should represent the year-end totals of the report year (December 31, 2007) and be consistent with the Utah specific data reported on the NAIC Annual Statement for 2007.

Please note that direct insured business means business where the insurance company bears the underwriting risk prior to ceding or assumption and should include all Utah residents (even if your company wrote the policy in another state and the insured member later moved into Utah). If your company did not report any direct accident and health insurance business in Utah (i.e., zero reported for direct accident and health business in Utah on the Utah State page), then your company is exempt from filing the survey form.

The survey form is divided into eight major parts:

In part I, companies report detailed information regarding all of the fully insured accident health business in Utah during 2007. The information reported here should balance to the Utah State page of NAIC Annual Statement.

In part II, companies report the various lines of accident & health business that were being actively marketed in Utah during 2007.

In part III, companies with Medicare product business in Utah report detailed membership data for Medicare Supplement, Medicare Advantage (Part C), and Medicare Part D plans. The information reported here should balance to the information reported in part I.

In part IV, companies with Long-Term Care business in Utah report additional detail and membership data for their Long-Term Care plans. The information reported here should balance to the information reported in part I.

In part V, companies with Comprehensive Hospital & Medical business provide additional detail regarding group size and plan types for their Comprehensive Hospital & Medical business. The information reported here should balance to the information reported in part I.

In part VI, companies report membership and claim data for administrative services of self-funded health benefit plans.

In part VII, companies report additional detail for certain types of administrative services. This category was created for a select number of companies with special circumstances. Most companies will not need to use this category.

In part VIII, all health insurers or Health Maintenance Organizations licensed under the Utah State Insurance Code shall file annually with the Utah Insurance Department a list of all value-added benefits offered at no cost to its enrollees. Attach a copy of your company's list of value-added benefits at the end of the survey.

PART I: UTAH INSURED ACCIDENT & HEALTH BUSINESS

COLUMN DEFINITIONS

NUMBER OF INSURED MEMBERS:	For individual policies, the number of insured members must include dependents. For group policies, the number of insured members must equal the number of certificate holders plus dependents.
NUMBER OF INSURED POLICIES:	For individual policies, enter the number of insured policyholders. For group policies, enter the number of certificate holders.
DIRECT PREMIUMS WRITTEN:	Enter the total premiums collected for policies written during the report year for each A&H insurance category.
DIRECT PREMIUMS EARNED:	Enter the portion of premium paid by the insured that was allocated to the insurer's loss experience, expenses, and profit during the report year for each A&H insurance category.
DIRECT LOSSES PAID:	Enter the actual amount of losses paid by the insurer during the report year for each A&H insurance category.
DIRECT LOSSES INCURRED:	Enter the total amount of losses incurred by the insurer during the report year for each A&H insurance category.

ROW DEFINITIONS

COMPREHENSIVE HOSPITAL & MEDICAL:	Business that includes major medical, comprehensive medical and other hospital-surgical-medical benefit plans designed to be the insured member's primary health benefit plan. If Comprehensive Hospital & Medical is reported, part V must also be completed.
MEDICAL ONLY:	Medical only contracts such as medical only, expense reimbursement and indemnity plans.
MEDICARE SUPPLEMENT:	Business reported in the Medicare Supplement Insurance Experience Exhibit of the annual statement. Includes all standardized and pre-standardized plans that are sold as a supplement to Medicare Part A and Part B. These plans serve only as a supplement to Medicare and do not cover the full cost of Medicare subscribers. Exclude all Medicare Advantage policies. If Medicare Supplement is reported, part III must also be completed.
MEDICARE ADVANTAGE:	Policies that qualify as Medicare Part C plans. Includes all full replacement policies that cover the full medical cost of Medicare subscribers. These plans are not sold as a supplement to Medicare, but are sold as a full replacement of Medicare coverage and provide additional benefits including pharmacy, hospital, and medical coverage beyond what Medicare typically covers. Exclude all Medicare Supplement policies. In the past, these plans have been reported under Title XVIII Medicare (see Title XVIII Medicare) or under Medicare Supplement (see Medicare Supplement). For the purposes of this survey, all Medicare Advantage polices are to be reported as a separate, unique product. If Medicare Advantage is reported, part III must also be completed.
MEDICARE PART D:	Policies that qualify as Medicare Part D plans. Includes all stand-alone pharmacy products that provide coverage for Medicare Part D, as well as plans that provide additional drug benefits beyond the minimum requirements for Medicare Part D. Exclude all Medicare Supplement and Medicare Advantage policies. If Medicare Part D is reported, part III must also be completed.
DENTAL ONLY:	Policies providing for dental only coverage issued as a stand alone dental or as a rider to a medical policy that is not related to the medical policy through deductibles or out-of-pocket limits.
VISION ONLY:	Policies providing for vision only coverage issued as stand alone vision or as a rider to a medical policy that is not related to the medical policy through deductibles or out-of-pocket limits.
FEDERAL EMPLOYEES (FEHBP):	Business allocable to the Federal Employees Health Benefit Plan premium.

Title XVIII MEDICARE:	Business where a premium is collected and the insurer covers the full medical costs of Medicare subscribers. Includes all specialized coverage that covers the full medical costs of Medicare subscribers, except for Medicare Advantage plans. Although Medicare Advantage plans technically qualify under this category, for the purposes of this survey, Medicare Advantage plans should be excluded from this section. Instead, report all Medicare Advantage plans under “Medicare Advantage” (see Medicare Advantage for details).
Title XIX MEDICAID:	Business where a premium is collected and the insurer covers the full medical costs of Medicaid subscribers.
STOP LOSS:	Stop loss insurance coverage for a self-insured group plan, a provider/provider group or non-proportional reinsurance of a medical insurance product.
DISABILITY INCOME:	Policies providing coverage for loss of income resulting from a disability.
LONG-TERM CARE:	Business allocable to Long Term Care coverage. If Long Term Care is reported, part IV must also be completed.
CREDIT A&H:	Policies providing for credit disability insurance. Excludes credit unemployment, credit life, and credit property insurance.
ALL OTHER A&H:	Other coverage not specifically addressed in any of the other categories.
TOTAL ACCIDENT AND HEALTH:	Sum total of all of the A&H categories listed previously. This line (line 16, part I) must balance with the total accident and health premium and losses reported on the Utah State page of the Annual Statement.

PART II: MARKETING OF ACCIDENT & HEALTH BUSINESS

In addition to reporting the accident & health business your company had in Utah during 2007, please note that your company must also provide information on the specific lines of accident & health business your company marketed in Utah during 2007.

PART II-A: MARKETING OF INSURED ACCIDENT & HEALTH BUSINESS IN UTAH

COMPREHENSIVE HOSPITAL & MEDICAL (TRADITIONAL):	Selling a policy that includes major medical, comprehensive medical and other hospital-surgical medical benefit plans designed to be the insured member's primary health benefit plan, and fits the definition of “Traditional Health Plans” as described in part V (see part V).
COMPREHENSIVE HOSPITAL & MEDICAL (HSA ELIGIBLE):	Selling a policy that includes major medical, comprehensive medical and other hospital-surgical medical benefit plans designed to be the insured member's primary health benefit plan, and fits the definition of “High Deductible Plans” as described in part V (see part V).
MEDICAL ONLY:	Selling medical only contracts such as medical only, expense reimbursement and indemnity plans.
MEDICARE SUPPLEMENT:	Selling Medicare Supplement policies that would be reported in the Medicare Supplement Insurance Experience Exhibit of the annual statement. If selling this type of business, see also part II-B.
MEDICARE ADVANTAGE:	Selling Medicare Advantage policies that qualify as Medicare Part C plans, and act as full replacement policies for Medicare, i.e., covers the full cost of Medicare subscribers in exchange for a premium. Insurance Experience Exhibit of the annual statement. If selling this type of business, see also part II-B.
MEDICARE PART D:	Selling policies providing stand-alone pharmacy only coverage that qualifies as a Medicare Part D plan.
DENTAL ONLY:	Selling policies providing for dental only coverage issued as a stand alone dental or as a rider to a medical policy that is not related to the medical policy through deductibles or out-of-pocket limits.
VISION ONLY:	Selling policies providing for vision only coverage issued as stand alone vision or as a rider to a medical policy that is not related to the medical policy through deductibles or out-of-pocket limits.
STOP LOSS:	Selling stop loss insurance coverage for a self-insured group plan, a provider/provider group or non-proportional reinsurance of a medical insurance product.
DISABILITY INCOME:	Selling policies providing coverage for loss of income resulting from a disability.
LONG-TERM CARE:	Selling policies that provide Long-Term Care coverage.
CREDIT A&H:	Selling policies providing for credit disability insurance. Excludes credit unemployment, credit life, and credit property insurance.
ALL OTHER A&H:	Selling accident & health coverage not specifically addressed in any of the other categories.
COMPANY NOT SELLING A&H:	If your company is ***not*** actively selling any form of accident & health insurance (e.g., all previous categories are “NO” or “FALSE”), enter “YES” or “TRUE” in this category. Otherwise enter “NO”.

PART III: MEDICARE PRODUCT BUSINESS

This section provides additional detail on Medicare Product business in Utah. If your company reports Medicare Supplement business in line 3, part I; Medicare Advantage business in line 4, part I; or Medicare Part D business in line 5, part I, then your company must complete this section.

PART III-A: AGE AND GENDER STATISTICS FOR MEDICARE SUPPLEMENT BUSINESS IN UTAH

To complete this section, take the total membership in Utah with Medicare Supplement coverage and divide the members by age and gender. To calculate each member's age, start with all of the members that were enrolled in a Medicare Supplement plan in Utah as of December 31, 2007. There should be the same number of members that were reported in line 3, column 1, part I. Use the member's date of birth to determine the age of the member (in years) as of December 31, 2007. Most database software currently in use has a function that will count the number of years between two dates (e.g., between the date of birth and December 31, 2007). Use the calculated age in years for each member to classify the membership into the following categories.

COLUMN CATEGORIES

NUMBER OF MALE MEMBERS:	The total number of men with Medicare Supplement coverage. Lines 1 through 7 should total to line 8.
NUMBER OF FEMALE MEMBERS:	The total number of women with Medicare Supplement coverage. Lines 1 through 7 should total to line 8.
TOTAL NUMBER OF MEMBERS:	The total number of members with Medicare Supplement coverage. Lines 1 through 7 should total to line 8. The number of male and female members should equal the total number of members. The total number of members reported here should balance to the number of insured members reported in line 3, column 1, part I.

ROW CATEGORIES

Age 0-59	Members age 59 or younger.
Age 60-64	Members between the ages of 60 to 64.
Age 65-69	Members between the ages of 65 to 69.
Age 70-74	Members between the ages of 70 to 74.
Age 75-79	Members between the ages of 75 to 79.
Age 80-84	Members between the ages of 80 to 84.
Age 85 and older	Members age 85 or older.
Total Members	Total members regardless of age. Lines 1 through 7 (the previous 7 categories) should total to line 8 (this category). The total number of members reported here should balance to the number of insured members reported in line 3, column 1, part I.

PART III-B: MEDICARE SUPPLEMENT MEMBERSHIP IN UTAH BY PLAN TYPE

To complete this section, take the total membership in Utah with Medicare Supplement coverage as of December 31, 2007 and classify the members by the standardized Medicare Supplement plans listed on the survey form. The total number of members reported here should balance to the number of insured members reported in line 3, column 1, part I.

PART III-C: AGE AND GENDER STATISTICS FOR MEDICARE ADVANTGE BUSINESS IN UTAH

To complete this section, take the total membership in Utah with Medicare Advantage coverage and divide the members by age and gender. To calculate each member's age, start with all of the members that were enrolled in a Medicare Advantage plan in Utah as of December 31, 2007. There should be the same number of members that were reported in line 3, column 1, part I. Use the member's date of birth to determine the age of the member (in years) as of December 31, 2007. Most database software currently in use has a function that will count the number of years between two dates (e.g., between the date of birth and December 31, 2007). Use the calculated age in years for each member to classify the membership into the following categories.

COLUMN CATEGORIES

NUMBER OF MALE MEMBERS:	The total number of men with Medicare Advantage coverage. Lines 1 through 7 should total to line 8.
NUMBER OF FEMALE MEMBERS:	The total number of women with Medicare Advantage coverage. Lines 1 through 7 should total to line 8.

TOTAL NUMBER OF MEMBERS:	The total number of members with Medicare Advantage coverage. Lines 1 through 7 should total to line 8. The number of male and female members should equal the total number of members. The total number of members reported here should balance to the number of insured members reported in line 4, column 1, part I.

ROW CATEGORIES

Age 0-59	Members age 59 or younger.
Age 60-64	Members between the ages of 60 to 64.
Age 65-69	Members between the ages of 65 to 69.
Age 70-74	Members between the ages of 70 to 74.
Age 75-79	Members between the ages of 75 to 79.
Age 80-84	Members between the ages of 80 to 84.
Age 85 and older	Members age 85 or older.
Total Members	Total members regardless of age. Lines 1 through 7 (the previous 7 categories) should total to line 8 (this category). The total number of members reported here should balance to the number of insured members reported in line 4, column 1, part I.

PART III-D: AGE AND GENDER STATISTICS FOR MEDICARE PART D BUSINESS IN UTAH

To complete this section, take the total membership in Utah with Medicare Part D coverage and divide the members by age and gender. To calculate each member's age, start with all of the members that were enrolled in a Medicare Part D plan in Utah as of December 31, 2007. There should be the same number of members that were reported in line 3, column 1, part I. Use the member's date of birth to determine the age of the member (in years) as of December 31, 2007. Most database software currently in use has a function that will count the number of years between two dates (e.g., between the date of birth and December 31, 2007). Use the calculated age in years for each member to classify the membership into the following categories.

COLUMN CATEGORIES

NUMBER OF MALE MEMBERS:	The total number of men with Medicare Part D coverage. Lines 1 through 7 should total to line 8.
NUMBER OF FEMALE MEMBERS:	The total number of women with Medicare Part D coverage. Lines 1 through 7 should total to line 8.
TOTAL NUMBER OF MEMBERS:	The total number of members with Medicare Part D coverage. Lines 1 through 7 should total to line 8. The number of male and female members should equal the total number of members. The total number of members reported here should balance to the number of insured members reported in line 4, column 1, part I.

ROW CATEGORIES

Age 0-59	Members age 59 or younger.
Age 60-64	Members between the ages of 60 to 64.
Age 65-69	Members between the ages of 65 to 69.
Age 70-74	Members between the ages of 70 to 74.
Age 75-79	Members between the ages of 75 to 79.
Age 80-84	Members between the ages of 80 to 84.
Age 85 and older	Members age 85 or older.
Total Members	Total members regardless of age. Lines 1 through 7 (the previous 7 categories) should total to line 8 (this category). The total number of members reported here should balance to the number of insured members reported in line 4, column 1, part I.

PART IV: LONG-TERM CARE BUSINESS

This section provides additional detail on Long-Term Care business in Utah. If your company reports Long Term Care business in line 11, part I, then your company must complete this section.

PART IV-A: UTAH INSURED LONG TERM CARE BUSINESS ONLY

COLUMN DEFINITIONS

NUMBER OF INSURED MEMBERS:	For individual policies, the number of insured members must include dependents. For group policies, the number of insured members must equal the number of certificate holders plus dependents.
NUMBER OF INSURED POLICIES:	For individual policies, enter the number of insured policyholders. For group policies, enter the number of certificate holders.
DIRECT PREMIUMS WRITTEN:	Enter the total premiums collected for policies written during the report year.
DIRECT PREMIUMS EARNED:	Enter the portion of premium paid by the insured that was allocated to the insurer's loss experience, expenses, and profit during the report year.
DIRECT LOSSES PAID:	Enter the actual amount of losses paid by the insurer during the report year.
DIRECT LOSSES INCURRED:	Enter the total amount of losses incurred by the insurer during the report year.

ROW DEFNITIONS

INDIVIDUAL:	Long-Term Care policies issued to an individual person.
GROUP (2 or more):	Long-Term Care policies issued to a group organization.
TOTAL:	Sum total of individual and group Long-Term Care policies.

PART IV-B: AGE AND GENDER STATISTICS FOR LONG-TERM CARE BUSINESS IN UTAH

To complete this section, take the total membership in Utah with Long-Term Care coverage and divide the members by age and gender. To calculate each member's age, start with all of the members that were enrolled in a Long-Term Care plan in Utah as of December 31, 2007. There should be the same number of members that were reported in line 3, column 1, part I. Use the member's date of birth to determine the age of the member (in years) as of December 31, 2007. Most database software currently in use has a function that will count the number of years between two dates (e.g., between the date of birth and December 31, 2007). Use the calculated age in years for each member to classify the membership into the following categories.

COLUMN CATEGORIES

NUMBER OF MALE MEMBERS:	The total number of men with Long-Term Care coverage. Lines 1 through 7 should total to line 8.
NUMBER OF FEMALE MEMBERS:	The total number of women with Long-Term Care coverage. Lines 1 through 7 should total to line 8.
TOTAL NUMBER OF MEMBERS:	The total number of members with Long-Term Care coverage. Lines 1 through 7 should total to line 8. The number of male and female members should equal the total number of members. The total number of members reported here should balance to the number of insured members reported in line 13, column 1, part I.

ROW CATEGORIES

Age 0-59	Members age 59 or younger.
Age 60-64	Members between the ages of 60 to 64.
Age 65-69	Members between the ages of 65 to 69.
Age 70-74	Members between the ages of 70 to 74.
Age 75-79	Members between the ages of 75 to 79.
Age 80-84	Members between the ages of 80 to 84.
Age 85 and older	Members age 85 or older.
Total Members	Total members regardless of age. Lines 1 through 7 (the previous 7 categories) should total to line 8 (this category). The total number of members reported here should balance to the number of insured members reported in line 13, column 1, part I.

PART V: COMPREHENSIVE HOSPITAL & MEDICAL BUSINESS

This section provides additional detail on Comprehensive Hospital & Medical business in Utah. If your company reports Comprehensive Hospital & Medical business in line 1, part I, then your company must complete this section.

COLUMN DEFINITIONS

NUMBER OF INSURED MEMBERS:	For individual policies, the number of insured members must include dependents. For group policies, the number of insured members must equal the number of certificate holders plus dependents.
CUMULATIVE MEMBER MONTHS:	Enter the cumulative year-end member months for each comprehensive hospital & medical plan category. If you report comprehensive premium, you must report member months, even if the insured members is zero at the end of the calendar year. To calculate member months, first count the number of insured members during each month of the year. This produces 12 member counts (one for each month). Then sum total all 12 member counts. This total is the cumulative member months for the year. For example, if your company had 10 insured members during each of the 12 months of the year, the cumulative member months would be calculated as follows: 10 members x 12 months = 120 member months.
DIRECT PREMIUMS WRITTEN:	Enter the total premiums collected for policies written during the report year.
DIRECT PREMIUMS EARNED:	Enter the portion of premium paid by the insured that was allocated to the insurer's loss experience, expenses, and profit during the report year.
DIRECT LOSSES PAID:	Enter the actual amount of losses paid by the insurer during the report.
DIRECT LOSSES INCURRED:	Enter the total amount of losses incurred by the insurer during the report year.

ROW DEFINTIONS

Group Categories

INDIVIDUAL:	Insured policies issued to an individual person. Exclude individual conversion policies.
SMALL GROUP (2 to 50):	Uses HIPPA definition of small group size. Insured policies issued to a group organization.
LARGE GROUP (51 or more):	Uses HIPPA definition of large group size. Insured policies issued to a group organization.
CONVERSION:	Individual insured policies that have been converted from a group insured policy.
GRAND TOTAL COMPREHENSIVE:	Total insured comprehensive hospital & medical business in Utah. This line (line 5.0, part V) must balance with the comprehensive hospital & medical data reported on line 1, part I.

Product Categories

TRADITIONAL HEALTH PLANS:	Any standard comprehensive or major medical policy regardless of deductible (e.g., if it is not eligible as a High Deductible Health Plan for use with a Health Savings Account, it is categorized as "Traditional"). Classifications include FFS, PPO, PPO w / POS features, HMO, and HMO w / POS features. Exclude all HSA eligible high deductible plans.
HIGH DEDUCTIBLE PLANS: (HSA Eligible)	Any comprehensive or major medical policy that qualifies as a High Deductible Health Plan under the Federal eligibility requirements for use with a Health Savings Account (HSA). Classifications include HDHP. Exclude any plan that is not an HSA eligible health plan (e.g., All traditional health plans).

PART V: COMPREHENSIVE HOSPITAL & MEDICAL BUSINESS (CONTINUED)

Plan Categories

INDEMNITY / FEE FOR SERVICE PLAN (FFS):	Under a Traditional Indemnity or Fee For Service plan (FFS), the insured member can use any provider they choose (as long as the services are a covered benefit under the insurance plan). There are no preferred provider networks and all services are reimbursed at the same cost sharing level (usually a fixed percentage of billed charges) regardless of which provider they choose. The insured member usually has a fixed coinsurance rate above the deductible. Only licensed Accident & Health insurers can offer FFS plans in Utah. However, if the FFS plan includes a PPO rider that allows individuals to pay a lower co-payment or coinsurance rate when they visit doctors or obtain medical services from a network of preferred providers, then the plan should be classified as a PPO for the purposes of the survey (see "Preferred Provider Organization Plan (PPO):").
PREFERRED PROVIDER ORGANIZATION PLAN (PPO):	Under a Preferred Provider Organization plan (PPO), the insured member has lower deductibles and coinsurance if they use physicians or hospitals in the preferred provider network. PPOs cannot limit members to the preferred provider network only, as this would be an EPO arrangement and PPOs are prohibited from doing this under Utah code. Rather, members have a financial incentive to stay within the preferred provider network, as costs are lower if they use preferred providers. Members are free to use any provider outside the network, but services are reimbursed at a lower rate and typically members must pay higher costs to do so. Only licensed Accident & Health insurers can offer PPO plans in Utah. However, if the PPO plan requires permission from a primary physician or gatekeeper, or requires some other form of pre-authorization prior to receiving services from a non-preferred provider that is outside of the network, then the plan should be classified as a PPO with POS features for the purposes of the survey (see "Preferred Provider Organization Plan with Point of Service Features (PPO w / POS):").
PREFERRED PROVIDER ORGANIZATION PLAN WITH POINT OF SERVICE FEATURES (PPO w / POS features):	Special category for certain types of PPOs. Use this category if the PPO plan requires permission from a primary physician or gatekeeper, or requires some other form of pre-authorization prior to receiving services from a non-preferred provider that is outside of the network). See also "Preferred Provider Organization Plan (PPO):"
HEALTH MAINTENANCE ORGANIZATION PLAN (HMO):	Under a Health Maintenance Organization plan (HMO), the member must use the HMO network providers exclusively, except in the case of an emergency. No services provided outside of the HMO network are covered. Only licensed HMOs can offer HMO plans in Utah. However, if the HMO plan has a point-of-service, indemnity carve out, out-of-network rider, or other option where members may use providers who are outside of the HMO network for routine medical services (not emergencies), but at a lower reimbursement rate (e.g., costs the member more to use non-network providers), then the plan should be classified as HMO with POS features for the purposes of the survey.
HEALTH MAINTENANCE ORGANIZATION PLAN WITH POINT OF SERVICE FEATURES (HMO w / POS features):	Special category for certain types of HMOs. Use this category if the HMO plan has a point-of-service, indemnity carve out, out-of-network rider, or other option where members may use providers who are outside of the HMO network for routine medical services (not emergencies), but at a lower reimbursement rate (e.g., costs the member more to use non-network providers). See also "Health Maintenance Organization Plan (HMO):"
OTHER PLANS:	Use the all other category for plans that do not fit into any of the previous categories. If this category is used, you should include a brief description of the plan features and explain why the other categories are not applicable.
HIGH DEDUCTIBLE HEALTH PLAN (HDHP):	Any comprehensive or major medical policy with a high deductible that qualifies as a High Deductible Health Plan under the Federal eligibility requirements for use with a Health Savings Account (HSA). Licensed Accident & Health insurers as well as licensed Health Maintenance Organizations can offer HDHP plans in Utah.

PART VI: ADMINISTRATIVE SERVICES FOR UTAH SELF-FUNDED HEALTH BENEFIT PLANS

SELF-FUNDED MEDICAL PLANS:	This category refers to any administrative business (third party administration, administrative services only, or administrative services contract) with a self-funded or ERISA eligible employer-sponsored medical plan in the State of Utah.

COLUMN DEFINITIONS

NUMBER OF MEMBERS:	Enter the total number of members in self-funded health benefit plans administered by the insurer.
ADMIN. INCOME:	Enter the total dollar amount of administrative income received by the insurer for administrating self-funded health benefit plans.
CLAIM ACTIVITY:	Enter the total dollar amount of claims processed by the insurer while administrating self-funded or insured medical plans.

ROW DEFINITIONS

(See “Plan Categories” in part V)

PART VII: ADMINISTRATIVE SERVICES FOR FEHBP, MEDICARE, AND MEDICAID BUSINESS

You should only complete this section if your company provides administrative services only (ASO), administrative services contracts (ASC) and other non-underwritten administrative business related to the Federal Employee Health Benefit Plan (FEHBP), Utah Medicaid, Federal Medicare programs, or other type of administrative services that the Utah Insurance Department needs additional information on. Exclude all business reported under self-funded health benefit plans. All data should be current as of December 31, 2007. Most companies who need this category have already been instructed to use it. If you have questions on whether you should use this category, contact Jeff Hawley.

PART VIII: VALUE-ADDED BENEFITS (see U.C.A. 31A-8a-207)

All health insurers or Health Maintenance Organizations licensed under the Utah State Insurance Code shall file annually with the Utah Insurance Department a list of all value-added benefits offered at no cost to its enrollees. Please attach a copy of your company’s list of value-added benefits at the end of this survey.